

Exhibit J

IN re PAXIL

PHILADELPHIA COURT OF COMMON PLEAS
OCTOBER TERM, 2004 No. 1503

SUICIDE / SUICIDALITY FACT SHEET

Each Plaintiff filing a lawsuit against SmithKline Beecham Corporation d/b/a GlaxoSmithKline alleging suicide or suicidality (i.e., suicidal thoughts, acts or gestures) involving the use of Paxil® ("Paxil"), Paxil CR® ("Paxil CR") and paroxetine must complete this form on behalf of THEMSELVES or on the behalf of the DECEASED PARTY for whom they bring the lawsuit. In completing this form, you are under oath and must provide information that is true and correct. If you cannot recall all of the details requested, please provide as much information as you can. You may and should consult records in your possession that contain responsive information to assist you in responding. You may be requested to provide copies of such documentation that is in your possession. You may attach as many sheets of paper as is necessary to answer these questions.

I. PLAINTIFF AND / OR DECEDENT INDIVIDUAL INFORMATION

A. Please state the complete name of the person who allegedly was injured by ingesting Paxil, Paxil CR or paroxetine: _____

• If filling out for a deceased person or a minor, please give your name and relationship to the decedent or minor: _____

B. Identify other names by which the injured or deceased may have been known, including, but not limited to maiden, prior married, nicknames, and aliases: _____

C. Sex of Plaintiff or Decedent: Male: _____ Female: _____

D. Date of Birth: _____ Place of Birth: _____

E. Please state whether the individual who allegedly was injured by ingesting Paxil, Paxil CR or paroxetine is living or deceased.

Living _____ Deceased _____

If deceased, please provide the date and cause of death: _____

F. Current or Most Recent Address (Street, City, State, Zip Code): _____

G. List every address at which plaintiff or decedent resided with dates of residence at location; identity of all persons who also resided at that location; relationship of such persons to plaintiff or decedent; and whether the property was owned or rented.

H. Please list all Social Security Numbers ever issued to plaintiff or decedent: _____

I. Please provide current or most recent driver's license number and state of issue for plaintiff or decedent: _____

J. On the date of the alleged claim of injury in this action, what was the marital / relational status of plaintiff or decedent?

Never married _____ Single: _____ Legally married and living together: _____

Common law union: _____ Divorced: _____ Widowed: _____

Married but separated: _____ Domestic Partner: _____ Significant Other: _____

1. Please provide the complete name of the spouse, deceased spouse, partner or significant other: _____

2. Please provide the Social Security number of the spouse, deceased spouse, partner or significant other: _____

3. If any children were born of this marriage or relationship, please give the complete names and dates of birth:

5. If suing on behalf of the deceased, what is the name of the Personal Representative of the Estate and the relationship to the decedent?

K. If plaintiff or decedent has ever been married before, please provide the name and address of each prior spouse; date and place of marriage; duration of marriage; date and means by which the marriage was terminated; and names and birthdates of each child or stepchild from that marriage, and whether or not child support was received or ordered to be paid:

1. Spouses, date of marriage, duration of marriage, and means of termination of marriage: _____

2. Children or Step-children: _____

3. If plaintiff or decedent was receiving or was ordered to pay child support, please specify person paying child support, recipient of child support, and amount of the payments: _____

L. Please indicate plaintiff's current marital status, if different from Section I, Part J, and if married, provide the name, date of birth, and Social Security number of plaintiff's spouse.

M. Provide the following information regarding your or the decedent's educational background, including but not limited to elementary, primary, junior high, high, trade, or vocational schools; colleges and universities; professional schools; and graduate schools [use and attach additional pages if needed]:

Name of School	Address	Grades Completed	Year Graduated

N. Was plaintiff or plaintiff's decedent ever a party to a civil lawsuit (other than the present action), arbitration, worker's compensation hearing, or EEOC hearing?

YES _____ NO _____

If yes, please respond to sections 1, 2, and 3:

1. State the style or caption of the case; whether plaintiff or decedent was a plaintiff or a defendant; when, where, and in what court the action was filed; the identity of all parties other than the plaintiff or decedent; the nature of each claim, counterclaim, and cross claim; and the disposition of the case: _____

2. If the lawsuit was a claim for damages or for compensation for personal injuries, in addition to the above information, state the date of the injury; the nature of the injury; the amount of damages or compensation sought; the amount of damages or compensation received, if any; and the identity of the person, firm, or corporation who paid any damages or compensation [use and attach additional pages if needed]: _____

3. The name and address of the attorney who represented you or the decedent in the lawsuit: _____

O. If any criminal charge was ever filed against plaintiff or decedent, including without limitation for driving under the influence of alcohol and/or drugs ("DUI") or driving while intoxicated ("DWI") due to alcohol and/or drugs, for each such charge state the nature of the charge; date of the alleged offense; the date of arrest, if applicable; the circumstances surrounding the incident; the disposition of the charge (whether plaintiff or decedent pled guilty, was convicted or acquitted after trial or the charge was dismissed); if plaintiff or decedent was convicted, the date for the conviction, the charge for which plaintiff or decedent was convicted; the name and address of the court where the proceedings took place; and any sentence plaintiff or decedent received [use and attach additional pages if needed].

P. Identify every insurance company to which plaintiff or plaintiff's decedent ever applied for life, health, COBRA, cancer, accident, liability, vehicle, home, umbrella, or disability insurance or from which such insurance coverage was ever sought on the plaintiff's or decedent's behalf, including but not limited to any group insurance [use and attach additional pages if needed]: _____

1. For each such application, state the type of insurance sought, the date of application, whether a policy was issued, any policy numbers assigned, the agency through which each application was submitted, the time period during which the policy was in effect, the date of and reason for denial of the application or cancellation of the policy (if applicable), and whether plaintiff or decedent ever submitted any claim for benefits: _____

2. If plaintiff or decedent ever submitted a claim, state for each such claim the date the claim was submitted, the nature of the claim, the place where the claim arose, the identity of the person or office to whom the claim was submitted, and any action taken on the claim: _____

Q. Please state whether plaintiff or any other person or entity acting on behalf of plaintiff's decedent executed a settlement or release with any person or party or received any type of payment from any source (including insurance companies, governmental agencies, doctors, and entities) in connection with or arising from the events alleged to be the results of ingesting Paxil, Paxil CR or paroxetine?

YES _____ NO _____

1. If yes, please describe the terms of such settlement or release and identify from whom any payments have been received, the amount and manner of each such payment, what claims were released, and any documents executed in connection with each such payment: _____

R. During the time when plaintiff or decedent was taking Paxil, Paxil CR or paroxetine, did plaintiff or decedent:

1. Consume alcohol? YES _____ NO _____

If Yes, please identify:

a. The type of alcohol consumed (e.g. beer, wine, liquors): _____

b. Number of drinks per week: _____

c. Number of days per week alcohol consumed: _____

d. Did this consumption differ while taking Paxil, Paxil CR or paroxetine?

YES _____ NO _____

If Yes, how? _____

2. Chew, consume, ingest, inject, snort, smoke or use tobacco and/or any illegal/non-medicinal drugs? YES _____ NO _____

If Yes, please identify:

a. The type of product(s) or substance(s) consumed, ingested, smoked or used: _____

b. Amount used per week: _____

c. Number of days per week used: _____

d. Did this substance use differ from any ordinary habits while on Paxil, Paxil CR or paroxetine? YES _____ NO _____

If Yes, how? _____

S. Identify all instances / occasions on which plaintiff or plaintiff's decedent sought, obtained or received treatment or counseling for drug or alcohol abuse, addiction, or dependency, including date(s), names and addresses of health care providers, counselors, or facilities; drugs / substances involved; and nature, duration, and outcome of treatment [use and attach additional pages if needed]: _____

T. Please state the hobbies and/or activities in which plaintiff or decedent engaged when not working for his/her employer, and provide the names of all social, charitable, service, fraternal or religious organizations to which plaintiff or decedent belonged during the last twenty (20) years preceding the events in question, along with dates of membership [use and attach additional pages if needed]: _____

U. Please provide the names and addresses of the five (5) persons believed to be plaintiff's or decedent's closest friends:

1. _____
2. _____
3. _____
4. _____
5. _____

II. EMPLOYMENT INFORMATION

A. Are you currently or was the decedent prior to death employed?

YES _____ NO _____

If Yes, please provide the following information:

1. The name of the employer: _____
2. The address of the employer: _____
3. Date started and ended: _____
4. Job title and responsibilities: _____
5. Name of supervisor: _____

B. Provide the following information for prior employers, including self-employment, military service, and volunteer work [use and attach additional pages if needed]:

	Job #1	Job #2	Job #3	Job #4
Employer Name				
Address				
Job Title				
Supervisor				
Date Started/ Ended				
Duties				
Wages / Salary				
Reason for Leaving				

C. Within the past twenty (20) years, have you or the decedent ever applied for worker's compensation, social security, or state or federal disability benefits?

YES _____ NO _____

If Yes, as to each application, provide the following information [use and attach additional pages if needed]:

Date of Application	Type of Benefits	Basis of Your Claim	Amount Awarded	If Denied, Reason for Denial

Date of Application	Type of Benefits	Basis of Your Claim	Amount Awarded	If Denied, Reason for Denial

III. INFORMATION ON PLAINTIFF'S OR DECEDENT'S FAMILY

A. Identify the members of plaintiff's or decedent's family of origin, including biological or adoptive parents, step-parents, in-laws, siblings, step-siblings, half-siblings, foster siblings, aunts, uncles, cousins, and grandparents. Give each person's full name along with any and all other names or aliases that the person ever used or by which the person was ever known; the person's date and place of birth; all Social Security numbers used by the person; the person's current address and if applicable, the date, place and cause of the person's death [use and attach additional pages if needed]

Names	Dates and Places of Birth	Social Security Numbers	Current Address	Death Information

B. Describe any instances of suicide, attempted suicide, homicide, attempted homicide, other violent or criminal behavior, drug or alcohol dependence or abuse, depression, or mental illness by any of plaintiff's or decedent's family members, including but not limited to grandparents, parents, siblings, aunts, uncles, cousins, spouses, or children.

1. For each such instance, state the name and address of the person; the person's relationship to plaintiff or decedent; and the nature of the suicide, attempted suicide, homicide, attempted homicide, other violent or criminal

behavior, drug or alcohol dependence or abuse, or mental illness, and the nature of the treatment received, if any [use and attach additional pages if needed].

IV. MEDICAL AND MENTAL HEALTH ISSUES FOR PLAINTIFF OR DECEDENT

APPLICABLE DEFINITIONS

As used herein, the terms listed below are defined as follows:

Health Care Provider - Any provider of healthcare, including physicians, osteopaths, medical doctors, psychologists, psychiatrists, nurses, nurse practitioners, physician's assistants, school nurses, school nurse practitioners, lay therapists, rehabilitation specialists, counselors, physical therapists, pharmacists, dentists, mental health specialists, substance abuse treatment personnel, and alternative health care practitioners such as, but not limited to, chiropractors, acupuncturists, herbalists or homeopathic medicine specialists.

Health Care Facility - All hospitals, clinics, outpatient facilities, health departments, medical offices, laboratories, substance abuse treatment centers, and all other locations at which medical care, treatment or medication is provided by any Health Care Provider.

Mental Health Issue - Any disease or condition affecting or influencing the way a person thinks, feels, behaves and/or relates to others and to his or her surroundings. Such conditions include but are not limited to those which are biological, psychodynamic, cognitive, behavioral, interpersonal, familial, psychological, psychiatric, or environmental in nature and/or any other stressors or trauma that influence or trigger such conditions in a person susceptible to such factors. Examples of Mental Health Issues include but are not limited to: depression, anxiety, aggression, agitation, hallucinations, violence tendencies, suicidal thoughts, suicidal plans, suicidal acts or gestures, completed suicides, akathisia, panic or panic disorder, bipolar disorder, manic depressive illness, schizophrenia, personality disorder, phobia, physical dependence, psychological dependence, addiction, substance abuse, and any other condition that affects the health or well-being of a person.

A. Identify each Health Care Provider with whom plaintiff or decedent ever consulted or who ever examined plaintiff or decedent for any routine physical examination or for any mental or physical illness, injury, condition, or disability; the illness, injury, condition, or disability for which the decedent sought or received examination, consultation, or treatment. Provide the name and address of the Health Care

Provider, the specialty of the Health Care Provider; reasons for seeking care, and the dates of all such examinations, consultations, and treatments [use and attach additional pages if needed].

Name and Address	Specialty	Reasons and Dates of Care or Treatments

B. Identify each Health Care Facility at which the decedent was ever hospitalized or at which Plaintiff's decedent ever received care, treatment, or medication, inpatient or outpatient, for any mental or physical illness, injury, condition, or disability, and for each such Health Care Facility state the address; illness, injury, condition, or disability for which the decedent was hospitalized, confined, treated, or received medication or care; the dates during which Plaintiff's decedent was hospitalized or confined or on which the decedent received such care, treatment, or medication; and the type or nature of the care, treatment, or medication the decedent received [use and attach additional pages if needed].

Health Care Facility and Address	Dates of Care or Treatment	Reason for Treatment	Nature of Care Received

Health Care Facility and Address	Dates of Care or Treatment	Reason for Treatment	Nature of Care Received

- C. Identify all medical conditions, health problems, injuries, and surgical procedures plaintiff or decedent had prior to or unrelated to any alleged injury or condition related to this present claim regarding use of Paxil, Paxil CR or paroxetine. For each condition, problem, injury or procedure, give the diagnosis and name of health care provider who made it, date of diagnosis, treatment rendered, and date(s) of treatment or ongoing condition / treatment.

Condition, Problem, Injury or Procedure	Health Care Provider and Date of Diagnosis	Treatment Rendered	Date(s) of Treatment vs. Ongoing Treatment

- D. State plaintiff's or decedent's history of mental health issues prior to the ingestion of Paxil, Paxil CR or paroxetine, including the type of mental health issue, thoughts of suicide, suicidal plans, suicidal acts or gestures, and suicide attempts; the date of first diagnosis or the event; the health care provider who made the diagnosis or provided evaluation or treatment; the date(s) of treatment; and whether each mental health issue was resolved or is ongoing [use and attach additional pages if needed].

Mental Health Issues	Health Care Provider and Date of Diagnosis	Treatment Rendered	Ongoing vs. Resolved

- E. Please state the names of any type of medication, drug or dietary supplement, either prescribed or over-the-counter, including vitamins and herbal preparations that

plaintiff is taking or plaintiff or decedent have taken in the last twenty (20) years [use and attach additional pages if needed].

1. For each such medication, drug or supplement: state the name of the medication, drug or supplement; dosage(s) of each such medication, drug or supplement; the time period during which plaintiff or decedent took each medication, drug or supplement; the illness or condition for which each medication, drug or supplement drug was/is being taken; and the health care provider who prescribed the medication, drug or supplement:

F. Provide the names and addresses of all pharmacies at which plaintiff or decedent filled the prescriptions for medications, including those for Paxil, Paxil CR or paroxetine, in the last twenty (20) years. This includes all drug stores, supermarkets, hospital pharmacies, or any other location from which medications were purchased or obtained [use and attach additional pages if needed].

G. Paxil, Paxil CR or Paroxetine Therapy

1. State the name, address and telephone number of each health care provider who provided or prescribed Paxil, Paxil CR or paroxetine for plaintiff or decedent [use and attach additional pages if needed]:

2. Set forth the date(s) Paxil, Paxil CR or paroxetine was provided or prescribed, the recommended dosage in milligrams, and the number of times per day that plaintiff or decedent were instructed to take Paxil, Paxil CR or paroxetine [use and attach additional pages if needed]: _____

3. If samples of Paxil, Paxil CR or paroxetine were provided by any health care provider, please describe the type and dose(s) of the Paxil samples, the number of samples dispensed, the name of the health care provider who dispensed the samples, and the date such samples were dispensed [use and attach additional pages if needed]:

4. Please identify the names and addresses of each person with personal knowledge of plaintiff's or decedent's ingestion of Paxil, Paxil CR or paroxetine [use and attach additional pages if needed]:

5. Please state over what period of time plaintiff or decedent ingested Paxil, Paxil CR or paroxetine, the time frame for each dose if on more than one dose during that period, and the last date of ingestion [use and attach additional pages if needed]:

V. CLAIMS OF INJURIES AND ALLEGED DAMAGES

A. Describe in detail each and every injury, illness, symptom, side effect, adverse reaction, medical or physical problem, or psychiatric or psychological condition plaintiff claims to have experienced or plaintiff claims decedent experienced as a result of ingesting Paxil, Paxil CR or paroxetine, and the date of onset for each [use and attach additional pages if needed]:

1. Did plaintiff or decedent ever receive medical or mental health evaluation or treatment from a health care provider for the injuries or conditions claimed to have been caused by the ingestion of Paxil, Paxil CR or paroxetine?

YES _____ NO _____

If Yes, please identify the date(s) on which plaintiff or decedent first saw a healthcare provider; the name and address of each health care provider; the reasons evaluation, treatment, or counseling were sought; and the nature of such evaluation, treatment, or counseling [use and attach additional pages if needed]:

2. Did any health care provider ever tell plaintiff or decedent that that any of the symptoms, conditions or injuries which plaintiff or decedent claimed to be the result of ingesting Paxil, Paxil CR or paroxetine were in fact related to the ingestion of Paxil, Paxil CR or paroxetine?

YES _____ NO _____

If Yes, please identify the health care provider by name and address; state what evaluations, examinations or tests that were performed to determine this; and which symptoms, injuries or conditions the health care provider attributed to the ingestion of Paxil, Paxil CR or paroxetine [use and attach additional pages if needed]:

3. Did any health care provider ever tell plaintiff or decedent that that any of the symptoms, conditions or injuries which plaintiff or decedent claimed to be the

YES _____ NO _____

[illegible]

D. Is plaintiff claiming any emotional injuries or distress or other intangible damages as a result of any events alleged to have occurred related to plaintiff's or decedent's ingestion of Paxil, Paxil CR or paroxetine?

YES _____ NO _____

If Yes, please describe in detail:

E. Is plaintiff claiming any damages related to plaintiff's or decedent's employment arising from the alleged ingestion of Paxil, Paxil CR or paroxetine?

YES _____ NO _____

If Yes, please describe these damages and produce documentation as requested in the Request for Documents.

F. If plaintiff is claiming any other economic damages, please describe these and specify the monetary value [use and attach additional pages if needed].

G. Please describe in detail the basis or bases for computation, calculation, or measure of any damages sought by plaintiff on behalf of himself or herself and/or on behalf of plaintiff's decedent, including the identity of all persons having any knowledge or information concerning such damages or the computation, calculation or measure thereof; and the identity of all documents relating or referring to plaintiff's or decedent's alleged damages and to the computation, calculation or measure of plaintiff's or decedent's alleged damages [use and attach additional pages if needed]:

VI. OTHER

- A. Has plaintiff or decedent, prior to death, ever visited any websites containing information about Paxil, Paxil CR or paroxetine?

YES _____ NO _____

If Yes, please provide the website addresses below:

- B. Has plaintiff or decedent, prior to death, ever visited any chat rooms or boards, such as self-help, support, message or sounding boards, regarding Paxil or other Selective Serotonin Reuptake Inhibitors (SSRIs); Paxil, Paxil CR or paroxetine use; or Paxil, Paxil CR or paroxetine or other SSRI litigation?

YES _____ NO _____

If Yes, please provide the website addresses below:

- C. Has plaintiff or decedent, prior to death, ever communicated via e-mail or chat room regarding Paxil, Paxil CR or paroxetine or other Selective Serotonin Reuptake Inhibitors (SSRIs); Paxil, Paxil CR or paroxetine use; or Paxil, Paxil CR or paroxetine or other SSRI litigation (other than communications with your attorneys and/or their employees).

YES _____ NO _____

If Yes, please provide the website addresses below:

- D. Did plaintiff or decedent, prior to death, ever receive any brochures, pamphlets or other documents about Paxil, Paxil CR or paroxetine from any health care provider (as defined in section IV)?

YES _____ NO _____

If Yes, please identify for each: what was received; from whom it was received; when it was received; and what it said. If you have any of this material in your possession, please attach it to this form, pursuant to the Request for Documents.

- E. Has plaintiff or decedent, prior to death, ever read any print advertisements (including those on the Internet) about Paxil, Paxil CR or paroxetine?

YES _____ NO _____

If Yes, please identify for each: the date the print advertisement was read; the publication in which it appeared; and what it stated. If you have any of this material in your possession, please attach it to this form.

- F. Has plaintiff or decedent, prior to death, ever seen any television advertisements about Paxil, Paxil CR or paroxetine?

YES _____ NO _____

If Yes, please identify for each: what was seen; when it was seen; the television station on which it appeared; and what it said.

- G. Please list the dates of each communication of any kind between plaintiff's or decedent's treating physician(s) or any representative or attorney for plaintiff's or decedent's treating physician(s), and any attorney for plaintiff or decedent, or any other person on behalf of any attorney for plaintiff or decedent, and describe the substance of each communication.

H. Please list any dates of communication of any kind between plaintiff or decedent or any attorney or representative for plaintiff or decedent and GlaxoSmithKline, and describe the nature of each communication.

I declare under penalty of perjury subject to 18 Pa. CS. § 4904 that all of the information provided in this Plaintiff's Fact Sheet is true and correct to the best of my knowledge, information and belief that I have supplied all the documents requested in this Plaintiff's Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

Further, by signing below, I waive notice under the Pennsylvania Rules of Civil Procedure, or other applicable law or rule, of subpoenas or other requests for production of medical records directed to health care providers identified in this Plaintiff's Fact Sheet.

Plaintiffs Name (Signature)*

Plaintiffs Name (Printed)

Date

Requests for Documents
[Check the appropriate box]

1. Sign the attached Medical Authorization (Release "A") permitting the disclosure of medical records and medical expenses. (This release includes both doctors and hospitals.)

☐ The executed release is attached.

☐ The executed release has been given to my attorney.
2. Sign the attached Education Authorization (Release "B") permitting the disclosure of your educational records.

☐ The executed release is attached.

☐ The executed release has been given to my attorney.
3. Sign the attached Employment Authorization (Release "C") permitting the disclosure of your employment records.

☐ The executed release is attached.

☐ The executed release has been given to my attorney.
4. Sign the attached Insurance Authorization (Release "D") permitting the disclosure of your insurance records and reports.

☐ The executed release is attached.

☐ The executed release has been given to my attorney.
5. Sign the attached Tax Records Authorization (Release "E") permitting the disclosure of your tax records.

☐ The executed release is attached.

☐ The executed release has been given to my attorney.
6. Sign the attached Worker's Compensation Authorization (Release "F") permitting the disclosure of your worker's compensation claims.

- ☐ The executed release is attached.
- ☐ The executed release has been given to my attorney.
7. Sign the attached Psychotherapy Authorization (Release "G") permitting the disclosure of your psychotherapy notes and expenses.
- ☐ The executed release is attached.
- ☐ The executed release has been given to my attorney.
8. Sign the attached Social Security Authorization (Release "H") permitting the disclosure of your social security disability claims.
- ☐ The executed release is attached.
- ☐ The executed release has been given to my attorney.
9. All medical records related to plaintiff or decedent currently in your possession, including pharmacy records, autopsy and toxicology reports, death certificates, and police records.
- ☐ I have no documents responsive to this request.
- ☐ The responsive documents are attached.
10. Any documents, including personal or professional letters, diaries, calendars, journals, logs, date books, video or audio tapes, or other documents, materials, or things of plaintiff's or decedent's or any member of plaintiff's or decedent's families, relating to the circumstances and events, including but not limited to plaintiff's or decedent's medical care, treatment, diagnosis, or emotional, psychological, or psychiatric illness(es), disorder(s), condition(s), concern(s) or death; and economic damages claimed.
- ☐ I have no documents responsive to this request.
- ☐ The responsive documents are attached.
11. Any materials in your possession that you may have received from psychiatrists, psychologists, physicians, or other health care providers who have treated you for any of the conditions which you claim are related to your use of Paxil, Paxil CR or paroxetine.

(This would include any consent forms or other materials supplied to you by the doctor(s) who prescribed you Paxil, Paxil CR or paroxetine.)

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

12. Any literature or materials in your possession that you may have received (from sources other than your attorney) regarding use of Paxil, Paxil CR or paroxetine. (This would include, but not be limited to, materials provided to you by health care providers, newsletters and materials from support groups and materials from governmental agencies or medical organizations.)

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

13. Any materials in your possession that you may have received from a defendant. (This would include but not be limited to any correspondence you may have received if you made a claim to the defendant company prior to bringing your lawsuit as well as product literature or product brochures relating to your use of Paxil, Paxil CR or paroxetine.)

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

14. Any materials, documents or correspondence you have generated or gathered that you have in your possession which relate to your use of Paxil, Paxil CR or paroxetine. (This includes but is not limited to letters you have written to physicians, defendants, government agencies or support groups. It also includes any research you may have personally undertaken regarding your physical or mental condition.)

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

15. Any documents you have in your possession which identify the manufacturer, health care provider, pharmacy or other person or entity of any SSRI, SNRI (Serotonin Norepinephrine Reuptake Inhibitors) or other antidepressant or mental health medication you have received. (This would include but not be limited to any product literature, package inserts, product brochures, notes or instructions.)

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

16. All medical or other bills in your possession that you are claiming as damages in your lawsuit, including but not limited to funeral, burial or any pre-death damages, or any other bills you contend were incurred as a result of the acts or omissions of the defendant.

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

17. Any documents in your possession which show any reimbursement you may have received for any of the medical bills you are claiming as damages in your lawsuit, or any evidence regarding denial or lack of coverage of any item of special damages claimed.

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

18. If you are claiming loss of past or future wages, produce your W-2 forms for those years in which you are claiming a loss and for the five-year period preceding the year of your first loss.

☐ I am not claiming lost wages.

☐ The responsive documents are attached.

19. If you are claiming loss of self-employment income, then produce those portions of your tax returns which relate to the loss for each year in which you are claiming a loss and for the five-year period preceding the year of your first loss.

☐ I am not claiming loss of self-employment income.

☐ The responsive documents are attached.

20. If you have received disability benefits in connection with any of the medical conditions alleged in your lawsuit, produce documents in your possession which reflect payment of these benefits, including but not limited to worker's compensation, unemployment benefits, Social Security, or any other available disability supplement or support of any kind.

☐ I have not received any such benefits.

☐ The responsive documents are attached.

21. If you have been the subject of any media coverage regarding Paxil, Paxil CR, paroxetine or other SSRIs, produce copies of the materials which document the media coverage. If you do not have copies of these materials, describe the media coverage including the date of its publication or broadcast.

☐ I have not been the subject of any media coverage.

☐ The responsive documents are attached.

☐ I do not have the responsive materials but I have been the subject of the following media coverage:

22. Any policies or contracts identified in response to Section I, Part P of the Suicide / Suicidality Fact Sheet.

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

23. Any documents executed pursuant to any settlement or release or any payment received identified in response to Section I, Part P of the Suicide / Suicidality Fact Sheet.

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

24. Any documents evidencing or relating to any secured or unsecured loans, debts or other financial liabilities applied for or incurred by plaintiff or decedent, including but not limited documents related to deeds of trust, promissory notes, mortgages, lines of credit,

automobile loans, other loan financing agreements, credit card or charge card statements, retail store or consumer credit account statements and credit reports.

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

25. Any documents evidencing or relating to any assets of plaintiff or decedent, including but not limited to bank statements, brokerage statements, real property valuations, personal property valuations and life insurance policies; any documents evidencing or relating to any bankruptcy petition or proceedings filed by plaintiff or decedent; and any documents evidencing or relating to communications between plaintiff or decedent and any credit counseling or debt counseling organizations within the twenty (20) years.

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

26. Any documents evidencing or relating to any legal separation or divorce proceedings identified in response to Section I, Part K of the Suicide / Suicidality Fact Sheet.

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

27. Any documents evidencing or relating to any child support payments identified in response to Section I, Part K-3 of the Suicide / Suicidality Fact Sheet.

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

28. Any documents evidencing or relating to any foreclosures or repossessions of decedent's real or personal property or termination or cancellation of services provided to decedent.

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

RELEASE A

AUTHORIZATION AND RELEASE FOR MEDICAL RECORDS

TO:

I hereby authorize all holders of all information relating to the medical diagnosis and treatment of _____ (the "Medical Information") to disclose the Medical Information to and for use by Dechert LLP, King & Spalding LLP, and any of their agents or designees. By way of example, the Medical Information includes, but is not limited to, the following:

All medical records, physicians' records, surgeons' records, x-rays, CAT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films, pathology materials, slides, tissues, laboratory reports, discharge summaries, progress notes, consultations, prescriptions, records of drug abuse and alcohol abuse, HIV/AIDS diagnosis or treatment, physicals and histories, discharge summaries, laboratory reports, medication records, nurses' notes, patient intake forms, correspondence, psychiatric records, psychological records, psychometric test results, social worker's records, insurance records, consents for treatment, statements of account, bills, invoices, or any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, diagnosis or other information pertaining to the physical or mental condition.

The Medical Information may be disclosed to and used by the Recipients in connection with a civil lawsuit brought by myself, my relatives or my heirs. I understand that my signing or revoking this Authorization will not affect my health care treatment, enrollment in my health plan, or eligibility for health benefits.

I understand that the Medical Information is confidential and that HIV/AIDS diagnosis and treatment records, and drug and alcohol abuse treatment records, are accorded specific protection by federal and/or state laws and regulations. By signing this authorization, I consent to the disclosure to and use by the Recipients of all Medical Information, including HIV/AIDS diagnosis and treatment records, and drug and alcohol abuse treatment records. You are hereby released from any and all liability in connection with your disclosure of Medical Information to the Recipients. I understand that, except as otherwise stated in this authorization, information disclosed pursuant to this authorization may be subject to redisclosure by the Recipients and may no longer be protected by privacy laws and regulations.

THIS PARAGRAPH APPLIES ONLY TO A PARTY REQUESTING EITHER HIV/AIDS INFORMATION FROM THE VETERANS ADMINISTRATION OR DRUG AND ALCOHOL ABUSE AND TREATMENT INFORMATION FROM ANY SOURCE: Prohibition on Redisclosure. This information is being disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person who is the subject of the information or is otherwise permitted by 42 C.F.R. Part 2 or 38 C.F.R. Part 1. A general authorization for the release of medical or other information is NOT sufficient

for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.

This authorization is continuing in nature and is to be given full force and until this authorization expires one year after it is signed. Notwithstanding the immediately preceding sentence, I understand that I may revoke this authorization at any time prior to its expiration by sending written notice of revocation to King & Spalding LLP, except to the extent that action already has been taken in reliance on this authorization.

Name of Patient

Signature of Patient

Former/Alias/Maiden Name of Patient

Date

Patient's Date of Birth

Name of Patient Representative (if applicable)

Patient's Social Security Number

Signature of Patient Representative

Patient's Address

Description of Authority to Act for Patient

Date

RELEASE B

**AUTHORIZATION AND RELEASE
FOR EDUCATIONAL RECORDS**

To:

I hereby authorize and request the above named educational institution to furnish to the law firms of Dechert LLP, King & Spalding LLP and any of their agents or designees copies of any and all recorded information concerning including by way of example, but not limited to the following:

all school records including application and admission paperwork, attendance records, transcripts, diplomas, health and physical examination records, immunization records, nurses notes, disciplinary records, correspondence and any and all other information and records pertaining to the above individual.

You are hereby released from any and all liability in connection with the disclosure of records, documents, writings and physical evidence to the above firms.

This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof.

This authorization also includes the authority to copy and inspect any and all such information.

A copy of this authorization may be used in place of and with the same force and effect as the original.

Name of Student

Signature

Former/Alias/Maiden Name of Student

Date

Date of Birth of Student

Social Security Number of Student

Address

RELEASE C

**AUTHORIZATION AND RELEASE
FOR EMPLOYMENT RECORDS**

To:

I, the undersigned, hereby authorize the above-named company, business, institution, firm or corporation, to release, upon presentation of this authorization, to law firms of Dechert LLP, King & Spalding LLP and any of their agents or designees, any material or information pertaining to the employment of _____, including by way of example, but not limited to the following:

All applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, disciplinary records, workers' compensation files; all hospital, physician, clinic, infirmary, nurse, psychiatric and dental records; x-rays, test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held; reasons for termination or leaving; and any other records concerning employment with the above-named institution.

You are hereby released from any and all liability in connection with the disclosure of records, documents, writings and physical evidence to the above firms.

This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof. This authorization also includes the authority to copy and inspect any and all such information. A copy of this authorization may be used in place of and with the same force and effect as the original.

Name of Employee

Signature

Former/Alias/Maiden Name of Employee

Date

Date of Birth of Employee

Social Security Number of Employee

RELEASE D

**AUTHORIZATION FOR RELEASE OF
INSURANCE RECORDS AND REPORTS**

To:

I, the undersigned, hereby authorize and request the above-named company to furnish to the law firms of King & Spalding LLP and Dechert LLP, and any of their agents or designees (collectively, the "Recipients"), copies of any and all of recorded information in the company's possession concerning (the "Insured"), for use in connection with a civil lawsuit brought by the Insured, the Insured's relatives or the Insured's heirs. By way of example, the information covered by this Authorization includes, but is not limited to, the following:

All applications for insurance coverage and renewals; insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; physician, hospital, psychiatric, psychological, and dental reports, prescriptions, correspondence, test results, radiological films and any other medical records submitted for claims review purposes; claims records; records of all litigation; and all other records of any kind concerning or pertaining to the Insured.

The Authorization includes the Recipients' authority to copy and inspect any and all such information.

You are hereby released from any and all liability in connection with the disclosure of information to the Recipients pursuant to this Authorization. I understand that information disclosed pursuant to this Authorization may be subject to redisclosure by the Recipients and may no longer be protected by privacy laws and regulations.

This Authorization is continuing in nature and is to be given full force and effect until conclusion of the civil lawsuit. Notwithstanding the immediately preceding sentence, I understand that I may revoke this authorization at any time prior to its expiration by sending written notice of revocation to (i) King & Spalding LLP, Attention: Todd P. Davis, 191 Peachtree Street, Atlanta, GA 30303; and (ii) Dechert LLP, Attention: Joseph Hetrick, 4000 Bell Atlantic Tower, 1717 Arch Street, Philadelphia, PA 19103-2793, except to the extent that action already has been taken in reliance on this Authorization. A photocopy of this Authorization shall have the same force and effect as the original.

Name of Insured

Signature of Insured or Insured's Authorized
Representative (if applicable)

Former/Alias/Maiden Name of Insured

Description of Authority to Act for Insured

Date of Birth of Insured

Date

Social Security Number of Insured

RELEASE E

Form **4506**

(Rev. September 2005)

Department of the Treasury
Internal Revenue Service**Request for Copy of Tax Return**▶ Do not sign this form unless all applicable lines have been completed.
Read the instructions on page 2.

▶ Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.

OMB No. 1545-0429

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a Tax Return Transcript for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See Form 4506-T, Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return	2b Second social security number if joint tax return
3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code	
4 Previous address shown on the last return filed if different from line 3	
5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.	

Caution: If a third party requires you to complete Form 4506, do not sign Form 4506 if lines 6 and 7 are blank.

6 Tax return requested (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶

Note. If the copies must be certified for court or administrative proceedings, check here. ☐

7 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

____/____/____	____/____/____	____/____/____	____/____/____
____/____/____	____/____/____	____/____/____	____/____/____

8 Fee. There is a \$39 fee for each return requested. Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.	
a Cost for each return	\$ 39.00
b Number of returns requested on line 7	
c Total cost. Multiply line 8a by line 8b	\$
9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here <input type="checkbox"/>	

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, either husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

Sign Here	Signature (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a ()
	Title (if line 1a above is a corporation, partnership, estate, or trust)		
	Spouse's signature	Date	

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 41721E

Form 4506 (Rev. 9-2005)

General Instructions

Section references are to the Internal Revenue Code.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate a third party to receive the tax return. See line 5.

How long will it take? It may take up to 60 calendar days for us to process your request.

Tip. Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

Note. If you are requesting more than one return and the chart below shows two different service centers, mail your request to the service center based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to the Internal Revenue Service at:
District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New York, Vermont	RAIVS Team 310 Lowell St. Stop 679 Andover, MA 01810
Alabama, Delaware, Florida, Georgia, North Carolina, Rhode Island, South Carolina, Virginia	RAIVS Team 4800 Buford Hwy. Stop 91 Chamblee, GA 30341
Arkansas, Kansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, Texas, West Virginia	RAIVS Team 3651 South Interregional Hwy. Stop 6716 Austin, TX 78741
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nebraska, Nevada, New Mexico, Oregon, South Dakota, Utah, Washington, Wyoming	RAIVS Team Stop 38101 Fresno, CA 93888
Connecticut, Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, North Dakota, Ohio, Wisconsin	RAIVS Team Stop 6705 Kansas City, MO 64999
New Jersey, Pennsylvania, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team OP SE 135 Philadelphia, PA 19255-0695

Chart for all other returns

If you lived in or your business was in:	Mail to the Internal Revenue Service at:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah, Washington, Wyoming	RAIVS Team Mail Stop 6734 Ogden, UT 84201
Connecticut, Delaware, District of Columbia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia, Wisconsin	RAIVS Team P.O. Box 145500 Stop 2800F Cincinnati, OH 45250

Line 1b. Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the return be sent to a third party, the IRS must receive Form 4506 within 60 days of the date signed by the taxpayer or it will be rejected.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the Letters Testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. Sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: Learning about the law or the form, 10 min.; Preparing the form, 16 min.; and Copying, assembling, and sending the form to the IRS, 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to Internal Revenue Service, Tax Products Coordinating Committee, SE:W-CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6406, Washington, DC 20224. Do not send the form to this address. Instead, see *Where to file* on this page.

Form 4506-T (Rev. 10-2005)

General Instructions

Purpose of form. Use Form 4506-T to request tax return information. You can also designate a third party to receive the information. See line 5.

Tip. Use Form 4506, Request for Copy of Tax Return, to request copies of tax returns.

Where to file. Mail or fax Form 4506-T to the address below for the state you lived in when that return was filed. There are two address charts: one for individual transcripts (Form 1040 series and Form W-2) and one for all other transcripts.

Note. If you are requesting more than one transcript or other product and the chart below shows two different service centers, mail your request to the service center based on the address of your most recent return.

Chart for individual transcripts (Form 1040 series and Form W-2)

If you filed an individual return and lived in:	Mail or fax to the Internal Revenue Service at:
District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New York, Vermont	RAIVS Team 310 Lowell St. Stop 679 Andover, MA 01810 978-247-9255
Alabama, Delaware, Florida, Georgia, North Carolina, Rhode Island, South Carolina, Virginia	RAIVS Team 4800 Buford Hwy. Stop 91 Chamblee, GA 30341 678-530-5326
Arkansas, Kansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, Texas, West Virginia	RAIVS Team 3651 South Interregional Hwy. Stop 6716 Austin, TX 78741 512-460-2272
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nebraska, Nevada, New Mexico, Oregon, South Dakota, Utah, Washington, Wyoming	RAIVS Team Stop 38101 Fresno, CA 93888 559-253-4990
Connecticut, Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, North Dakota, Ohio, Wisconsin	RAIVS Team Stop 6705 Kansas City, MO 64999 816-823-7667
New Jersey, Pennsylvania, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team OP SE 135 Philadelphia, PA 19255-0695 215-516-2931

Chart for all other transcripts

If you lived in or your business was in:	Mail or fax to the Internal Revenue Service at:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah, Washington, Wyoming	RAIVS Team Mail Stop 6734 Ogden, UT 84201 801-620-6922
Connecticut, Delaware, District of Columbia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia, Wisconsin	RAIVS Team P.O. Box 145500 Stop 2800F Cincinnati, OH 45250 859-669-3592

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 6. Enter only one tax form number per request.

Signature and date. Form 4506-T must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the information be sent to a third party, the IRS must receive Form 4506-T within 60 days of the date signed by the taxpayer or it will be rejected.

Individuals. Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506-T exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506-T can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506-T can be signed by any person who was a member of the partnership during any part of the tax period requested on line 9.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the Letters Testamentary authorizing an individual to act for an estate.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. Sections 6103 and 6109 require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103. The time needed to complete and file Form 4506-T will vary depending on individual circumstances. The estimated average time is: Learning about the law or the form, 10 min.; Preparing the form, 12 min.; and Copying, assembling, and sending the form to the IRS, 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-T simpler, we would be happy to hear from you. You can write to the Internal Revenue Service, Tax Products Coordinating Committee, SE:W-CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6406, Washington, DC 20224. Do not send the form to this address. Instead, see *Where to file* on this page.

RELEASE F

**AUTHORIZATION AND RELEASE
FOR WORKER'S COMPENSATION RECORDS**

To:

I hereby authorize and request the above named Worker's Compensation court, commission, agency, or insurance company to furnish to the law firms of Dechert LLP, King & Spalding LLP and any of their agents or designees, copies of any and all records in your possession relating in any way to employment of _____ and/or his/her health, including by way of example, but not limited to the following:

all worker's compensation claims, including claim petitions, judgments, findings; notices of hearings, hearing records, transcripts, decisions and orders, all depositions and reports of witnesses and expert witnesses; employer's accident reports, all other accident, injury, or incident reports; all medical records; records of payment made; investigatory reports and records; and any other records relating to the above-named; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians' hospital, medical, psychiatric, and health reports, x-rays; test results, physical examinations; any records relating to claims made relating to health, disability or accidents in which he/she was involved, including correspondence, reports, claim forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; any statements of account, bills or invoices.

You are hereby released from any and all liability in connection with the disclosure of records, documents, writings and physical evidence to the above firms.

This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof.

This authorization also includes the authority to copy and inspect any and all such information. A copy of this authorization may be used in place of and with the same force and effect as the original.

Name of Worker

Signature

Former/Alias/Maiden Name

Date of Birth of Worker

Date

Social Security Number of Worker

RELEASE G

**AUTHORIZATION AND RELEASE
FOR
PSYCHOTHERAPY NOTES**

I hereby EXPRESSLY AUTHORIZE all holders of all psychotherapy notes relating to _____ ("Psychotherapy Notes") to disclose the Psychotherapy Notes to and for use by Dechert LLP, King & Spalding LLP and any of their agents or designees (the "Recipients"). For purposes of this Authorization, Psychotherapy Notes includes notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session.

The Psychotherapy Notes may be disclosed to and used by the Recipients in connection with a civil lawsuit brought by myself, my relatives or my heirs. I understand that my signing or revoking this Authorization will not affect my health care treatment, enrollment in a health plan, or eligibility for health benefits.

I understand that drug and alcohol abuse treatment records are accorded specific protection by federal and/or state laws and regulations. By signing this Authorization, I consent to the disclosure to and use by the Recipients of all Psychotherapy Notes, including drug and alcohol abuse treatment records, if any. You are hereby released from any and all liability in connection with your disclosure of Psychotherapy Notes to the Recipients. I understand that, except as otherwise stated in this Authorization, information disclosed pursuant to this Authorization may be subject to redisclosure by the Recipients and may no longer be protected by privacy laws and regulations.

THIS PARAGRAPH APPLIES ONLY TO A PARTY REQUESTING DRUG AND ALCOHOL ABUSE AND TREATMENT INFORMATION FROM ANY SOURCE: Prohibition on Redisclosure. This information is being disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person who is the subject of the information or is otherwise permitted by 42 C.F.R. Part 2 or 38 C.F.R. Part 1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.

This Authorization is continuing in nature and is to be given full force and effect until this Authorization expires one year after it is signed. Notwithstanding the immediately preceding sentence, I understand that I may revoke this Authorization at any time prior to its expiration, except to the extent that action already has been taken in reliance on this Authorization, by sending written notice of revocation to King & Spalding LLP, Attention: Todd P. Davis, 191 Peachtree St., Atlanta, GA 30303.

Name of Patient

Signature of Patient

Former/Alias/Maiden Name of Patient

Date

Patient's Date of Birth

Name of Patient Representative (if applicable)

Patient's Social Security Number

Signature of Patient Representative

Patient's Address

Description of Authority to Act for Patient

Date

RELEASE H

**AUTHORIZATION AND RELEASE
FOR SOCIAL SECURITY DISABILITY RECORDS**

I hereby authorize and request all holders of all information relating to Social Security disability records of _____ to furnish copies of any and all such information to the law firm of King & Spalding LLP and any of its agents or designees. By way of example, the requested information includes, but is not limited to, the following:

All Social Security disability records and reports filed under Title II and/or Title XVI of the Social Security Act, including documents created by the Social Security Administration or its divisions, administrative departments, agencies, and commissions, as well as all testimony, rulings, expert opinions, consultations, opinions, reports, medical records, correspondence, and any and all other information and records.

You are hereby released from any and all liability in connection with the disclosure of records, documents, writings and physical evidence to the above firm.

This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof.

This authorization also includes the authority to copy and inspect any and all such information.

A copy of this authorization may be used in place of and with the same force and effect as the original.

_____ Name	_____ Signature
_____ Date of Birth	Sworn to before me this _____ day of _____, 20_____.
_____ Social Security Number	_____ Notary Public